A. Type of Handbook

Part B is the provider-specific Medicaid handbook for dental services. Part B includes information for providers on provider eligibility criteria, recipient eligibility, covered services, payment method, and billing instructions. Use this handbook in conjunction with Part A, the all-provider handbook, which includes general policy guidelines, regulations, and billing information applicable to all types of certified providers. Refer to the Provider Section of the Wisconsin Medicaid Managed Care Guide for general policy and regulation information for AFDC-related/Healthy Start recipients enrolled in a Medicaid HMO.

B. Provider Information

Provider Eligibility and Certification

To be eligible for Wisconsin Medicaid certification, dentists practicing in the state of Wisconsin are required to maintain an active license with the state Dental Examining Board according to section 447.05, Wis. Stats. Dentists practicing outside the state of Wisconsin who provide services to Wisconsin Medicaid recipients must be licensed by the Dental Examining Board in their own state.

Certification Determines Oral Surgery Billing

Wisconsin Medicaid uses provider specialties to determine which procedure coding system dentists will use in billing for oral surgeries. During the certification process, Wisconsin Medicaid asks dental providers to identify their practice specialties:

- Endodontics.
- Oral Pathology.
- Orthodontics.
- Periodontics.
- General Practice.
- Oral Surgery.
- Pedodontics.
- Prostdontics.

Dental providers who choose the oral surgery and oral pathology specialty use the American Medical Association's *Physicians' Current Procedural Terminology* (CPT) procedure codes for billing most oral surgeries. Dental providers with all other specialties use American Dental Association (ADA) Current Dental Terminology (CDT) procedure codes for billing most oral surgeries, as described in this handbook. Dentists who want different oral surgery billing than assigned to their specialty must complete a form requesting a change. Refer to Appendices 2 and 16 of this handbook for further information.

Certification for Laboratory Services

All laboratories which test human specimens to determine health status are covered by the federal Clinical Laboratory Improvement Amendments (CLIA) of 1988. CLIA governs every aspect of laboratory operation, including tests performed, personnel qualifications, quality control, quality assurance, proficiency testing, patient test management, and records and information systems. Every provider who performs laboratory tests must obtain a CLIA identification number *and* a certificate of waiver or a certificate of registration from the federal Health Care Financing Administration (HCFA). HCFA may grant a certificate of waiver to a laboratory that restricts its testing to the eight waived tests. This applies to clinics and individual provider offices that perform laboratory tests. Clinics

B. Provider Information (continued)

with laboratories located at more than one location must have a Wisconsin Medicaid billing provider number for every laboratory that has a CLIA identification number in order to receive the correct reimbursement for laboratory services.

Scope of Services

The policies in this handbook govern all dental services provided within the scope of the practice of the profession as defined in section 447.02, Wis. Stats., and HFS 107.07, Wis. Admin. Code. The covered services and related limitations are listed in Section II and in Appendices 9 through 19 of this handbook.

Reimbursement

The rate of reimbursement is based on the Medicaid dental maximum fee schedule. A provider is reimbursed the lesser of either the billed amount or the maximum fee allowable established by Wisconsin Medicaid (refer to Section IV-D of this handbook for more information). Wisconsin Medicaid has a maximum payment for all radiographs provided to a single recipient on a single day; for selected oral surgery emergency services provided to a single recipient on a single day; and for all dental services provided to a single recipient on a single day.

Provider Responsibilities

Refer to Section IV of Part A, the all-provider handbook, for information about the responsibilities of Medicaid-certified providers, including all of the following:

- Fair treatment of the recipient.
- Maintenance of records.
- Recipient requests for noncovered services.
- Services rendered to a recipient during periods of retroactive eligibility.
- Grounds for provider sanctions.
- Additional state and federal requirements.

Advisory Committee

The Wisconsin Dental Association (WDA) Access to Care Committee advises the Department of Health and Family Services (DHFS) and acts as a communication link between the DHFS and the provider community. The membership listing of the committee is available through the WDA.

Reducing the Number of Missed Appointments

The following suggestions will reduce missed appointments for all patients, including Medicaid recipients. When you schedule appointments, explain to patients the importance of keeping appointments and the office rules regarding missed appointments. Wisconsin Medicaid offers the following suggestions to decrease the “no show” rate:

- Contact the patient by telephone or postcard prior to the appointment and remind the

B. Provider Information (continued)

patient of the time and place of the appointment and the importance of canceling scheduled appointments in advance.

- Require patients to verify their appointment by calling the dental office, using the following procedures:
  1. Explain the policy carefully to your patients when they make appointments.
  2. Send postcards to remind them of their appointments, of the office policy regarding confirming their appointments, and of the need to call immediately to confirm the upcoming appointment.
  3. If they do not call by a given day before their appointment, give the appointment to another patient.
- If the appointment is made through the HealthCheck screening or targeted case management programs, encourage staff from those programs to ensure that scheduled appointments are kept.
- Call the local city/county health department or the HealthCheck Hotline at (800) 722-2295 for information about HealthCheck services in your area. Individual dentists may agree only to accept referrals from HealthCheck providers, such as the local public health agencies and physicians. Some health departments have outreach staff who might be able to assist recipients in getting to their dental appointments.
- Contact programs and agencies, such as HeadStart, sheltered workshops, or human service departments, to develop a referral system. Some of these agencies may assist recipients in finding transportation and keeping dental appointments.
- If a recipient needs assistance in paying for transportation to a medical appointment, encourage the recipient to call the county department of social or human services before the appointment.
- If a recipient is physically or mentally disabled, unable to take public transportation, and has a physician prescription verifying the disability, the recipient may call a Medicaid-certified specialized medical vehicle (SMV) provider for transportation.

WDA has distributed papers describing community models for delivery of dental emergency services and additional suggestions to reduce the "no-show" rate. Contact your local association for more information.

C. Recipient Information

Verifying Recipient Eligibility

Recipient eligibility information is available to providers from Wisconsin Medicaid's Eligibility Verification System (EVS). Providers can access EVS in a number of ways, including:

- Automated Voice Response (AVR) System.
- Eligibility Hotline.
- Dial-Up (Direct Information Access Line with Updates for Providers).

C. Recipient Information (continued)

Refer to Section I-C of Part A, the all-provider handbook, for more information about these methods of verifying recipient eligibility. For more information about recipient eligibility itself, refer to Section V of Part A.

Recipient Loss of Eligibility at Any Time During Treatment

If a recipient loses Medicaid eligibility at any time during treatment, Wisconsin Medicaid does *not* reimburse those services provided after eligibility has lapsed. (Refer to the exceptions for fixed and removable prosthodontics and orthodontic treatment noted later in this section.)

Note: For purposes of this section, loss of eligibility includes:

(a) Termination of coverage.
(b) Change in medical status.
(c) Change in age (e.g., the recipient exceeding the allowable age limitation for orthodontia).
(d) Enrollment in a Medicaid-contracted managed care program.

The recipient should present a valid Medicaid identification card to providers at each visit. Federal regulations deny federal matching funds for any services provided to ineligible recipients.

Recipients are financially responsible for any services received after their Medicaid eligibility is terminated. If the recipient wishes to continue treatment, it then becomes a decision between provider and patient whether the service should be provided and how payment will be made.

To avoid misunderstanding, Wisconsin Medicaid recommends that the provider remind recipients that they are responsible for any continued care.

To avoid potential reimbursement problems that can arise when a recipient loses eligibility during treatment, Wisconsin Medicaid encourages providers to follow these important procedures:

- When a recipient requires more than one office visit to complete treatment, the provider must verify the recipient's eligibility *on each visit*. Ask to see the recipient's Medicaid identification card each time.
- After the provider receives an approved prior authorization (PA) for a requested service, again verify the recipient's eligibility before proceeding with the approved service. *An approved PA does not guarantee recipient eligibility.* The recipient must be eligible on the day the service is provided, except as noted below.

Orthodontic Exception

The date of band placement for orthodontic treatment is the determination date for reimbursement. If a recipient becomes ineligible while receiving orthodontic treatment, Wisconsin Medicaid will continue to reimburse the dentist for completion of orthodontic

C. Recipient Information (continued)

services when bands are placed during the recipient's period of eligibility. If the recipient was eligible on the date the bands were placed, Wisconsin Medicaid will reimburse dentists *only for those services for which PA was granted*.

Prosthodontic Exception

The date of the final impression for prosthodontic services is the determination date for reimbursement. If a recipient becomes ineligible while receiving fixed or removable prosthodontic treatment, Wisconsin Medicaid will continue to reimburse the dentist for completion of prosthodontic services when final impressions were taken during the recipient's period of eligibility. If the recipient was eligible on the date the final impression was made, Wisconsin Medicaid will reimburse dentists *only for those services for which PA was granted*,

Wisconsin Medicaid makes these exceptions due to the complexity, cost, and long-term nature of prosthodontic and orthodontic treatment.

Benefit Category

Some Wisconsin Medicaid recipients do not have dental coverage or have very limited dental coverage due to their benefit category. Refer to Appendix 36 of this handbook or to Section V of Part A, the all-provider handbook, for additional information on benefit categories.

Recipients Enrolled in Managed Care Programs

Some recipients enrolled in Medicaid-contracted HMOs have dental coverage through their HMO. If a dentist without HMO affiliation provides *non-emergency* dental care to a Medicaid recipient with HMO dental coverage, neither the HMO nor Wisconsin Medicaid will reimburse the dentist for those services. Neither can the dentist hold the recipient liable.

Therefore, *before* providing any non-emergency dental services, a dentist should always check whether a Medicaid recipient is enrolled in an HMO and whether the HMO provides dental coverage. Eligibility information, including HMO dental coverage, is available through the Voice Response System, Dial-Up (the Wisconsin Medical Assistance Automated Information System), or the Eligibility Hotline. Refer to Section I-C of Part A, the all-provider handbook, for more information regarding these information systems.

If a dentist without HMO affiliation provides *emergency* dental care to a recipient with HMO dental coverage, the HMO will reimburse the dentist according to conditions of payment established in the HMO's contract with Wisconsin Medicaid. Refer to page B10 of this handbook for the definition of emergency dental care.

Dental providers are paid on a fee-for-service basis for managed care program enrollees if the managed care program does not offer dental services, or if the prosthodontia or orthodontia treatment began before the recipient was enrolled in a Wisconsin Medicaid-contracted managed care program. The determination dates for

C. Recipient Information (continued)

fee-for-service reimbursement for such treatments are as described under "Recipient Loss of Eligibility at Any Time During Treatment" in this section.

Refer to the Provider Section of the Wisconsin Medicaid Managed Care Guide for more information about managed care program noncovered services, emergency services, and hospitalizations.

Copayment

Except as noted below, all recipients are responsible for paying part of the cost involved in obtaining dental services. Refer to the maximum allowable fee schedule for procedure codes and their applicable copayment.

Wisconsin Medicaid bases the following copayment limitations on its maximum allowable fee for each code and not on the provider's billed amount:

Each service reimbursed at:	**Copay:**
• Up to $10.00	$0.50
• From $10.01 to $25.00	$1.00
• From $25.01 to $50.00	$2.00
• Over $50.00	$3.00

- Copayments for most CPT oral surgery codes is $3.00.

Refer to the maximum allowable fee schedule to determine the amount of copayment to charge for specific procedures.

Copayment exemptions include:

- Emergency services.
- Services provided to nursing home residents.
- Services provided to recipients under 18 years of age.
- Pregnant women who receive medical services related to the pregnancy or to another medical condition that may complicate the condition.
- Services covered by Medicaid-contracted managed care programs to enrollees of the managed care program.

All providers who perform services that require recipient copayment must make a reasonable attempt to collect that copayment from the recipient. Providers shall not, at their discretion, waive the recipient copayment requirement, unless the provider determines that the cost of collecting the payment, coinsurance, or deductible exceeds the amount to be collected. However, providers may not deny services to a recipient for failing to make a copayment.

Wisconsin Medicaid automatically deducts applicable copayment amounts from Medicaid

C. Recipient Information (continued)

payments. Do not reduce the billed amount on the claim by the amount of recipient copayment.

HealthCheck/Early and Periodic Screening, Diagnosis, and Treatment Requirements

HealthCheck is Wisconsin Medicaid's federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Through HealthCheck, children receive routine preventive medical check-ups, immunizations, and referrals. Certain dental services, such as orthodontia, are available to Wisconsin Medicaid recipients only after HealthCheck has been performed. Refer to Appendices 9 through 19 of this handbook for information on procedures that require HealthCheck. Refer to Section II-D and II-E of this handbook for more information on HealthCheck.

Specialized Medical Vehicle Transportation for Disabled Recipients

Wisconsin Medicaid covers necessary transportation to and from Wisconsin Medicaid-covered services. County human services departments and tribal agencies approve and pay for common carrier transportation by taxi, bus, or private car. Wisconsin Medicaid covers specialized medical vehicle (SMV) transportation for recipients who are temporarily or indefinitely physically or mentally disabled with conditions that contraindicate travel by common carrier.

The state Legislature adopted changes in HFS 107.23, Wis. Admin. Code, to reduce the costly and inappropriate use of SMVs by recipients. One of these changes requires a prescription signed by a referring health care provider, such as a dentist, for all SMV trips (except hospital or nursing home discharges) that exceed SMV one-way upper mileage limits.

A prescription is needed for trips that exceed 40 miles one-way and originate in one of the following counties:

- Brown.
- Dane.
- Fond du Lac.
- Kenosha.
- La Crosse.
- Manitowoc.
- Milwaukee.
- Outagamie.
- Sheboygan.
- Racine.
- Rock.
- Winnebago.

Wisconsin Medicaid requires a prescription for trips that exceed 70 miles one-way and originate in *any other* Wisconsin county.

If you refer a recipient who needs SMV transportation to a dental service that you suspect is farther away than the Wisconsin Medicaid one-way upper mileage limits, write a prescription for the recipient to show the SMV provider.
All recipients must have the physician SMV certification form on file before receiving SMV transportation.

The prescription should include the name of the health care provider or facility, the city

C. Recipient Information (continued)

where it is located, the service the recipient requires, and the amount of time the recipient needs transportation to the service. (Indicate time in days, not to exceed 365 days.)

Providers who may refer recipients and write SMV prescriptions are dentists, physicians, physician assistants, nurse midwives, nurse practitioners, optometrists, opticians, chiropractors, podiatrists, HealthCheck agencies, and family planning clinics.

Appendix 7 of this handbook provides an example of an SMV transportation prescription.

A. Introduction

Wisconsin Medicaid covers basic dental services within the categories of diagnostic, preventive, restorative, endodontic, periodontic, removable and fixed prosthodontic, oral and maxillofacial surgery, orthodontic, and adjunctive general services. These services are covered when provided by a Medicaid-certified dentist to an eligible Wisconsin Medicaid recipient according to the policies and procedures in this handbook.

Education in Preventive Care

Education of a Wisconsin Medicaid recipient in preventive care and the provision of dental health information is a component of all Medicaid-covered dental services, whenever appropriate. When provided, preventive training and information sharing should be documented in the recipient's dental records. Wisconsin Medicaid does not seperately reimburse these services.

Infection Control Charges

Providers should note that all Occupational Safety and Health Administration-mandated and other infection-control charges are included in Wisconsin Medicaid reimbursement. These costs may not be separately reimbursed or billed to the recipient.

Take-Home Supplies

Routine take-home supplies (e.g., gauze) are not separately reimbursable. Wisconsin Medicaid reimbursement of dental procedures includes routine take-home supplies needed before or after the procedure is performed. Recipients may not be charged for routine supplies.

Tooth Numbers and Letters

Wisconsin Medicaid recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" through "32" for permanent teeth. Wisconsin Medicaid also recognizes "SN" (super numerary) for teeth that cannot be classified under "A" through "T" or "1" through "32". Whenever a procedure applies to a specific tooth, these modifiers must be used in element 37 of the American Dental Association (ADA) claim form.

Denture Repair Modifiers

When billing the denture repair procedure codes, providers must indicate which denture is being repaired. Use the procedure code modifier "UU" for upper and "LL" for lower denture in element 37 of the ADA claim form.

Surgery Modifiers

Oral surgeons and oral pathologists billing *Current Procedural Technology* (CPT) codes for oral surgeries are to use modifier 80 in element 24D of the HCFA 1500 claim form to designate when a provider assists at surgery. Refer to the CPT code chart in Appendix 19 of this handbook to identify the services that allow reimbursement for assistance at surgery. Refer to Appendix 16 of this handbook for information on assisting at surgery using the ADA Current Dental Terminology (CDT) codes.

A. Introduction (continued)

Emergency Services

Wisconsin Medicaid covers emergency dental services. Certain dental services are covered only when they are provided under emergency circumstances (refer to Appendices 9 through 19 of this handbook).

Emergency dental care is defined as immediate service that must be provided to relieve the patient from pain, acute infection, swelling, trismus, fever, or trauma. In all emergency situations, the recipient's dental records must document the nature of the emergency and the treatment provided.

In emergency situations, Wisconsin Medicaid waives prior authorization (PA) requirements. For example, treatment of an abscessed tooth by opening the tooth for drainage is considered an emergency service, but completion of root canal therapy is *not* considered an emergency service. Wisconsin Medicaid also may waive PA for a hospital call, general anesthesia, and IV sedation.

Refer to Section III-A of this handbook for additional information on PA for emergency services. Emergency services are exempt from copayment. In addition, Wisconsin Medicaid has established a maximum reimbursement per patient per day for specific emergency services.

Refer to Section IV-H of this handbook for instructions on billing for emergency procedures.

B. Prescriptions

Within their scope of practice, dentists may prescribe drugs for Medicaid recipients. Before administering or prescribing any Schedule II, III, IV, or V pharmaceutical agents, the provider must also obtain a Drug Enforcement Administration (DEA) certification of registration. Wisconsin Medicaid does not reimburse providers for any charges associated with writing the prescription or for take-home drugs dispensed by a dentist.

Prescription Requirements

It is vital that the prescriber provide information sufficient for the dispensing provider to fill the prescription.

Except as otherwise provided in federal or state law, either the prescriber must write the prescription, or the pharmacist must take the prescription verbally from the prescriber. If the pharmacist takes the prescription verbally from the prescriber, the pharmacist must later put the prescription in writing. The prescription must include:

- The name and quantity of the drug or item prescribed.
- The date of issue of the prescription.
- The prescriber's name and address.
- The recipient's name and address.
- The prescriber's signature (if prescriber writes the prescription).
- The directions for use of the prescribed drug or item.

B. Prescriptions (continued)

For hospital and nursing home recipients, orders must be entered into the medical and nursing charts and must include the above information. Prescription orders are valid for no more than one year from the date of the prescription (except for controlled substances and prescriber-limited refills).

"Brand Medically Necessary" Requirements for Innovator Drugs

For a pharmacy to be reimbursed for a legend brand drug at a rate higher than that allowed for a generic equivalent, the prescribing provider must certify that a brand name drug is medically necessary by using the phrase "BRAND MEDICALLY NECESSARY" or "MEDICALLY NECESSARY" (instead of "NO SUBSTITUTES" or "N.S."). *This certification must be in the prescribing practitioner's own handwriting directly on the prescription order or on a separate authorization which is attached to the original prescription. Pharmacy orders must have this documentation prior to submitting claims to Wisconsin Medicaid*. In addition, the prescriber must document the reason in the recipient's medical record why the brand drug is medically necessary.

Typed certification, signature stamps, or certification handwritten by someone other than the prescriber does not satisfy this requirement. "Blanket" authorization for an individual recipient, drug, or prescriber is not acceptable documentation. A letter of certification is acceptable as long as the notation is handwritten, is for specified drugs for an individual recipient, and is valid for no more than one year. *While it is the pharmacy's responsibility to have this written documentation, it is the prescriber's responsibility to provide the pharmacy with the required documentation.*

Nursing Home Orders

Prescriber certification that the brand is medically necessary must be made on *each* prescription order written for nursing home recipients. This certification is good only for the length of time that the order is valid. Updated written certification is required for each new prescription order written.

Over-the-Counter Drugs

The "Brand Medically Necessary" provisions described for legend drugs do not apply to over-the-counter (OTC) drugs. Using a maximum allowable cost (MAC) formula based on generic prices, Wisconsin Medicaid reimburses providers who dispense OTCs described in Appendix 3 of this handbook. (Reimbursement for insulin and OTC ophthalmic lubricants is not limited to this MAC formula.) Higher reimbursement is not available for brand name OTC drugs when prescribers indicate "Brand Medically Necessary." Since Wisconsin Pharmacy Examining Board rules prohibit dispensing generic OTCs when brand name versions are prescribed, prescribers are encouraged to prescribe OTC drugs by their generic descriptions to prevent confusion.

Drug Rebate System

Wisconsin Medicaid utilizes a drug rebate system. The drug rebate system is the result of the federal Omnibus Budget Reconciliation Act of 1990. Manufacturers that have signed rebate agreements have their prescription drugs covered by Wisconsin Medicaid if the

B. Prescriptions (continued)

drugs meet Wisconsin Medicaid guidelines. Wisconsin Medicaid does not cover drugs produced by manufacturers that did not sign a rebate agreement, except as noted in Appendix 3 of this handbook. Under the drug rebate system, drug manufacturers that choose to participate in state Medicaid programs are required to sign rebate agreements with the federal Health Care Financing Administration (HCFA). Participation in the Medicaid program is voluntary on the part of the drug manufacturers. Rebate agreements are valid for one year. At the end of one year, manufacturers may choose whether or not to continue participation in the rebate program. Non-participating manufacturers have the option each quarter of signing a rebate agreement which is effective for the following quarter.

The prescriber may wish to contact a local Medicaid-certified pharmacy to confirm that Wisconsin Medicaid covers a particular drug or product.

Appendix 3 of this handbook is a list of the types of drugs that are covered by Wisconsin Medicaid, including those which require PA. Appendix 4 of this handbook lists *noncovered* drugs, including drugs sold by manufacturers that did not sign rebate agreements.

Documentation for Drugs Manufactured by Companies That Have Not Signed a Rebate Agreement

Wisconsin Medicaid recognizes that there are a few cases where it is medically necessary to provide a drug that is produced by a manufacturer that did not sign a rebate agreement. These drugs may be provided to the recipient when the *pharmacy* completes a PA request.

In this case, the prescriber must provide the following documentation to the pharmacy:

- A statement indicating that no other drug produced by a manufacturer that signed a rebate agreement is medically appropriate for the recipient.
- A statement indicating that Wisconsin Medicaid coverage of the drug is cost-effective for Wisconsin Medicaid.

A recipient request for a particular drug is not considered adequate justification for granting approval without the prescriber demonstrating medical necessity.

C. Covered Services

For a list of Medicaid-covered basic dental services, refer to Appendices 9 through 19 of this handbook.

Covered Services Information Handout

Dentists are encouraged to use the "Wisconsin Medicaid Covered Dental Services" informational handout when explaining Wisconsin Medicaid dental services to recipients (refer to Appendix 5 of this handbook).

D. HealthCheck

HealthCheck is Wisconsin Medicaid's federally-mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Through HealthCheck, children receive preventive medical check-ups, immunizations, and referrals.

To be eligible for a HealthCheck referral, a recipient must:

- Have a current Medicaid identification card.
- Be under 21 years of age.

When a recipient is enrolled in a Medicaid-contracted managed care program (indicated by a yellow Medicaid card), only the managed care program or its affiliated providers may provide the HealthCheck screening for that recipient.

Dentists can encourage recipients to obtain their HealthCheck screenings before their dental visits. This is particularly helpful when recipients have a medical need for orthodontia.

A dentist should refer the recipient to the HealthCheck Hotline telephone number listed in Appendix 1 of Part A, the all-provider handbook, to obtain a list of HealthCheck providers. A HealthCheck flyer is provided in Appendix 35 of this handbook for distribution to Wisconsin Medicaid recipients, or the HealthCheck referral form may be obtained by writing to:

Wisconsin Medicaid Claim Reorder
EDS
6406 Bridge Road
Madison, WI 53784-0003

Upon completion of a HealthCheck screening, eligible recipients may be given a HealthCheck Verification Card. This card assists the recipient in obtaining some Wisconsin Medicaid dental services because it verifies that a HealthCheck screening has been performed.

When providing a service that needs a HealthCheck screening (refer to HealthCheck "Other Services" below), dentists should make a photocopy of the card or keep in the recipient files signed and written evidence that a HealthCheck screening has occurred in the past year. The HealthCheck provider signature is required. No additional statement from the HealthCheck provider is needed. This evidence must be submitted with PA requests, but is not required for billing.

All Wisconsin Medicaid services resulting from a HealthCheck screening must be provided within one year of the screening date. A new HealthCheck screening must be performed if more than one year has passed since the previous screening.

E. HealthCheck "Other Services"

Wisconsin Medicaid covers orthodontia and some other dental services only if the child has received a HealthCheck exam. As a result of the federal Omnibus Budget Reconciliation Act of 1989 (OBRA), Wisconsin Medicaid considers requests for coverage of medically necessary dental services which are not specifically listed as covered services, or which are listed in this section as noncovered services, when all of the following conditions are met:

- The provider verifies that a comprehensive HealthCheck screening has been performed in the past year through a signed written document from the HealthCheck provider.
- The service is allowed under the Social Security Act as a "medical service."
- The service is "medically necessary" and "reasonable" to correct or ameliorate a condition or defect which is discovered during a HealthCheck screening.
- The service is noncovered under Wisconsin Medicaid.
- A service currently covered by Wisconsin Medicaid is not appropriate to treat the identified condition.

All requests for HealthCheck "Other Services" require PA. Refer to Section III of this handbook for information on requesting PA.

F. Inpatient and Outpatient Hospital Services

Inpatient and outpatient hospitalization is allowed on an emergency and non-emergency (elective) basis for some dental services.

Hospitalization for the express purpose of controlling apprehension is not a Medicaid-covered service. This policy applies to inpatient or outpatient hospital and ambulatory surgical centers.

If the request for hospitalization is for an institutionalized recipient, a physician's statement or order and an informed consent signed either by the recipient or the recipient's legal guardian is required.

Non-emergency hospitalization is appropriate in the following situations:

- Children with uncontrollable behavior in the dental office or with psychosomatic disorders that require special handling. Children needing extensive operative procedures such as multiple restorations, abscess treatments, or oral surgery procedures.
- Developmentally disabled recipients with a history of uncooperative behavior in the dental office, even with premedication.
- Hospitalized recipients who need extensive restorative or surgical procedures, or whose physician has requested a dental consultation.
- Geriatric recipients or other recipients whose medical history indicates that monitoring of vital signs or availability of resuscitative equipment is necessary during dental procedures.

F. Inpatient and Outpatient Hospital Services (continued)

- Medical history of uncontrolled bleeding, severe cerebral palsy, or other medical conditions that render in-office treatment impossible.
- Medical history of uncontrolled diabetes where oral and maxillofacial surgical procedures are being performed.
- Extensive oral and maxillofacial surgical procedures are being performed (e.g., Orthognathic, Cleft Palate, temporomandibular joint (TMJ) surgery).

For elective procedures, hospital calls are limited to two visits per stay and require PA.

All elective, non-emergency hospital services require PA if they require PA in other places of service, unless otherwise noted.

Hospital calls are limited to two visits per stay and require PA.

Emergency hospitalizations, hospital calls, and emergency outpatient services (emergency room and day surgery) do not require PA.

G. Noncovered Services

Under s. 49.46(2)(b), Wis. Stats., and under HFS 107.07(4), Wis. Admin. Code, Wisconsin Medicaid does not cover the following dental services:

- Dental implants and transplants.
- Fluoride mouth rinse.
- Services for purely aesthetic or cosmetic purposes.
- Overlay dentures, duplicate dentures, and related adjustments.
- Training in preventive dental care is not separately reimbursable.
- Cement bases as a separate item.
- Single unit crowns, except under HFS 107.07(1)(d)4 and HFS 107.07(a)5, Wis. Admin. Code.
- Precision attachments.
- Cast and prefabricated post and core.
- Professional visits, other than for the annual examination of a nursing home resident.
- Dispensing of drugs.
- Diagnostic casts, except when required for PA.
- Adjunctive periodontal services.
- Surgical removal of erupted teeth, except in emergency situations as stated in HFS 107.07(3), Wis. Admin. Code.
- Alveoplasty and stomatoplasty.
- All non-surgical medical or dental treatment for a TMJ condition.
- Osteoplasty, except as otherwise stated in HFS 107.07(2), Wis. Admin. Code.

G. Noncovered Services (continued)

In certain unusual circumstances, the Department of Health and Family Services (DHFS) may request that a noncovered service be performed, including, but not limited to, diagnostic casts in order to substantiate a PA request. In these cases the requested services can be reimbursed.